STATEMENT OF EMERGENCY

907 KAR 20:060E

(1) This is an emergency administrative regulation which amends the Medicaid adverse action and notice requirements regarding eligibility as a result of new eligibility rules and categories mandated by the Affordable Care Act. The Affordable Care Act mandates that effective January 1, 2014, that the eligibility standard for certain categories of individuals will be a modified adjusted gross income (or MAGI.) The MAGI differs from the income standard used for existing Medicaid eligibility categories. Additionally, the Affordable Care Act mandates a new eligibility category comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The Affordable Care Act bars the application of an income standard or resource standard (for eligibility determination purposes) to this population. Therefore, the Department for Medicaid Services is amending this administrative regulation to establish different requirements unique to the MAGI population and the former foster care population. As Medicaid coverage under the MAGI standards and for former foster care individuals is mandatory January 1, 2014 and eligibility determinations can begin October 1, 2013, this administrative regulation is necessary to be implemented on an emergency basis.

(2) This action must be implemented on an emergency basis to comply with a federal mandate.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

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Steven L. Beshear
Governor

_____

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Emergency Amendment)

907 KAR 20:060E[~~907 KAR 1:600~~]. Medicaid adverse action and conditions for recipients.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 431.210, 431.211, 431.213, 431.214, 42 U.S.C. 1396a, b, d[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes[~~sets forth~~] the conditions under which an application is denied or medical assistance is decreased or discontinued and advance notice requirements.

Section 1. [~~Definitions. (1) "Applicant" means an individual applying for Medicaid.~~

~~(2) "Application" means the process set forth in 907 KAR 1:610.~~

~~(3)"Medicaid coverage" means items or services a Medicaid recipient may receive through the Medicaid Program.~~

~~(4) "Recipient" means an individual who receives Medicaid.~~

~~Section 2.~~] Reasons for Adverse Action. (1) For an individual:

(a) Whose eligibility standard is not a modified adjusted gross income, an application for Medicaid eligibility shall be denied if:

1.[~~(a)~~] Income exceeds[~~or resources exceed~~] the standards as established in 907 KAR 20:020[~~set forth in 907 KAR 1:004~~];

2. Resources exceed the standard established in 907 KAR 20:025;

3.[~~(b)~~] The applicant does not meet technical eligibility criteria or fails to comply with a technical requirement as established in 907 KAR 20:005[~~set forth in 907 KAR 1:011~~];

4.[~~(c)~~] Despite receipt of written notice detailing the additional information needed for a determination, the applicant fails to provide sufficient information or clarify conflicting information necessary for a determination of eligibility;

5.[~~(d)~~] The applicant fails to keep the appointment for an interview without good cause;

6.[~~(e)~~] The applicant requests, in writing, voluntary withdrawal of the application without good cause;

7.[~~(f)~~] Staff are unable to locate the applicant; or

8.[~~(g)~~] The applicant is no longer domiciled in Kentucky;

(b) Whose eligibility standard is a modified adjusted gross income pursuant to 907 KAR 20:100, the application for Medicaid eligibility shall be denied if:

1. Income exceeds the standards as established in 907 KAR 20:100;

2. The applicant does not meet the citizenship, residency, and other technical require-

ments established in 907 KAR 20:100;

3. Despite receipt of written notice detailing the additional information needed for a determination, the applicant fails to provide sufficient information or clarify conflicting information necessary for a determination of eligibility;

4. The applicant fails to keep the appointment for an interview without good cause;

5. The applicant requests, in writing, voluntary withdrawal of the application without good cause;

6. Staff are unable to locate the applicant; or

7. The applicant is no longer domiciled in Kentucky; or

(c) Who is a former foster care individual between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage, an application for Medicaid shall be denied if:

1. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:075;

2. Despite receipt of written notice detailing the additional information needed for a determination, the applicant fails to provide sufficient information or clarify conflicting information necessary for a determination of eligibility;

3. The applicant fails to keep the appointment for an interview without good cause;

4. The applicant requests, in writing, voluntary withdrawal of the application without good cause;

5. Staff are unable to locate the applicant; or

6. The applicant is no longer domiciled in Kentucky.

(2) Medicaid eligibility shall be discontinued:

(a) For a recipient whose Medicaid eligibility income standard is not a modified adjusted gross income if:

1.[~~(a)~~] Income [~~or resources~~] of the recipient exceeds[~~exceed~~] the standards established in 907 KAR 20:020[~~set forth in 907 KAR 1:004~~];

2. Resources of the recipient exceed the standard established in 907 KAR 20:025;

3.[~~(b)~~] Deductions decrease[~~decease~~] resulting in income exceeding the standards established in 907 KAR 20:020[~~set forth in 907 KAR 1:004~~];

4.[~~(c)~~] The recipient does not meet technical eligibility criteria or fails to comply with a technical requirement as established in 907 KAR 20:005[~~set forth in 907 KAR 1:011~~];

5.[~~(d)~~] Despite receipt of written notice detailing the additional information needed for a redetermination, the recipient fails to provide sufficient information or clarify conflicting information necessary for a redetermination of eligibility;

6.[~~(e)~~] The recipient fails to keep the appointment for an interview;

7.[~~(f)~~] Staff are unable to locate the recipient;

8.~~(g)~~] The recipient is no longer domiciled in Kentucky; or

9.~~(h)~~] A change in program policy that adversely affects the recipient has occurred.

(b) For a recipient whose Medicaid eligibility income standard is a modified adjusted gross income if:

1. Income of the recipient exceeds the standards established in 907 KAR 20:100;

2. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:100;

3. Despite receipt of written notice detailing the additional information needed for a redetermination, the recipient fails to provide sufficient information or clarify conflicting in-

formation necessary for a redetermination of eligibility;

4. The recipient fails to keep the appointment for an interview;

5. Staff are unable to locate the recipient;

6. The recipient is no longer domiciled in Kentucky; or

7. A change in program policy that adversely affects the recipient has occurred.

(c) For a former foster care individual between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage if:

1. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:075;

2. Despite receipt of written notice detailing the additional information needed for a redetermination, the recipient fails to provide sufficient information or clarify conflicting information necessary for a redetermination of eligibility;

3. The recipient fails to keep the appointment for an interview;

4. Staff are unable to locate the recipient;

5. The recipient is no longer domiciled in Kentucky; or

6. A change in program policy that adversely affects the recipient has occurred.

(3) Patient liability shall be increased if:

(a) Income of the recipient increases; or

(b) Deductions decrease.

(4) Medicaid eligibility may be redetermined in another category resulting in a reduction of Medicaid coverage for an individual whose income eligibility standard is:

(a) Not a modified adjusted gross income, if:

1 [~~(a)~~]Income exceeds[~~or resources exceed~~] the standards established [~~as set forth~~] in

907 KAR 20:020[~~907 KAR 1:004~~]; or

2. The individual[~~(b) The recipient~~] does not meet technical eligibility requirements established in 907 KAR 20:005; or

(b) A modified adjusted gross income, if:

1. Income exceeds the standards established in 907 KAR 20:100; or

2. The individual does not meet the citizenship, residency, and other technical eligibility requirements established in 907 KAR 20:100[~~as set forth in 907 KAR 1:011~~].

(5) Medicaid coverage may be reduced due to a change in Medicaid coverage policy.

Section 2.[~~3.~~] Notification of Denial of Applications. If a Medicaid application is denied, the applicant shall be given written notification of the denial which shall include:

(1) The reason for the denial;

(2) The cites of the applicable state administrative regulation; and

(3) The right to an administrative[~~a fair~~] hearing as established in 907 KAR 20:065[~~set forth in 907 KAR 1:560~~].

Section 3.[~~4.~~] Advance Notice of a Discontinuance, Increase in Patient Liability, or a Reduction of Medicaid Coverage. (1) A[~~The~~] recipient shall be given ten (10) days advance notice of the proposed action if a change in circumstances indicates:

(a) A discontinuance of Medicaid coverage;

(b) An increase in patient liability; or

(c) A reduction of Medicaid coverage.

(2) A[~~The~~] recipient shall be given five (5) days advance notice of the proposed action if a change in circumstance indicates:

(a) Facts that action should be taken because of probable fraud by the recipient; and

(b) The facts have been verified through secondary sources.

(3) The ten (10) days advance notice and the five (5) days advance notice of proposed action shall:

(a) Be in writing;

(b) Explain the reason for the proposed action;

(c) Cite the applicable state administrative regulation;

(d) Explain the individual's right to request an administrative[~~a fair~~] hearing;

(e) Provide an explanation of the circumstances under which Medicaid is continued if an administrative[~~a~~] hearing is requested; and

(f) Include that the applicant or recipient may be represented by an attorney or other party if the applicant or recipient[~~he~~] so desires.

(4) An administrative[~~A~~] hearing request received during the advance notice period may result in a delay of the discontinuance of Medicaid coverage, a delay in an increase in patient liability, or delay of a reduction of Medicaid coverage pending the hearing officer's decision, as established in 907 KAR 20:065[~~set forth in 907 KAR 1:560~~].

Section 4.[~~5.~~] Exceptions to the Advance Notice Requirement. An advance notice of proposed action shall not be required, but written notice of action taken shall be given, if discontinuance of Medicaid coverage or an increase in patient liability resulted from:

(1) Information reported by the recipient if the recipient signs a waiver of the notice requirement indicating understanding of the consequences;

(2) A clear written statement, signed by the recipient, that the recipient[~~he~~] no longer wishes to receive Medicaid;

(3) Factual information is received that the recipient has died;

(4) Whereabouts of the recipient are unknown and mail addressed to the recipient[~~him~~] is returned indicating no known forwarding address;

(5) Establishment by the agency that Medicaid has been accepted in another state;

(6) The recipient enters:

(a) A penal institution; or

(b) If between twenty-one (21) and sixty-five (65) years of age, a mental hospital or an institution for mental disease (IMD); or

(7) A change in the level of medical care is prescribed by the recipient's physician.

Section 5. Expiration of Hospital or Psychiatric Residential Treatment Facility Stay. [~~6.~~] Expiration of an approved time-limited hospital or psychiatric residential treatment facility stay shall not constitute a termination, suspension, or reduction of benefits.

Section 6. Individuals Whose Income Eligibility Standard is a Modified Adjusted Gross Income. An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be an individual who is:

(1) A child under the age of nineteen (19) years, excluding children in foster care;

(2) A caretaker relative with income up to 133 percent of the federal poverty level;

(3) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(4) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

(a) Does not have a dependent child under the age of nineteen (19) years; and

(b) Is not otherwise eligible for Medicaid benefits; or

(5) A targeted low income child with income up to 150 percent of the federal poverty

level.

[~~Section 7. Material Incorporated by Reference. (1) The forms necessary for adverse action in the Medicaid Program are being incorporated effective April 1, 1995. These forms include the MA 105, revised July 1992 and the KIM 105, revised September 1992.~~

~~(2) material incorporated by reference may be reviewed at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621. Office hours are 8 a.m. to 4:30 p.m. Copies may be obtained from that office upon payment of the appropriate fee allowed by 200 KAR 1:020.~~]

907 KAR 20:060

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynesr, Secretary Cabinet for Health and Family Services

907 KAR 20:060

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on November 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by November 14, 2013 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business December 2, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 20:060
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the conditions under which an application for Medicaid is denied, medical assistance is decreased or discontinued, and related advance notice requirements.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program conditions and requirements addressed in paragraph (a) in accordance with federal law and regulation and as authorized by KRS 194A.030(2) which establishes the Department for Medicaid Services as the commonwealth's single state agency for administering the federal Social Security Act.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing the Medicaid program conditions and requirements addressed in paragraph (a).
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing the Medicaid program conditions and requirements addressed in paragraph (a).

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment establishes adverse action and notice requirements for individuals for whom the Medicaid income eligibility standard is a modified adjusted gross income (or MAGI) and for former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. These are two (2) new eligibility categories created by the Affordable Care Act and having eligibility requirements differing from the old/existing Medicaid eligibility rules. The MAGI group includes individuals previously eligible under the old rules but there is no resource standard for these individuals and their income is determined in a more simplified way under the new rules. The MAGI group also includes what is known as the expansion group which is a new eligibility group comprised of childless adults who do not otherwise qualify for Medicaid and have income up to 133 percent of the federal poverty level. The MAGI group in entirety is comprised of children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133

percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. Another new group – a group which is mandated by the Affordable Care Act – is comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. There is no income standard or resource standard for this group. The amendment also removes definitions from the administrative regulation as those are now being established in a definitions administrative regulation for all administrative regulations within the new chapter – Chapter 20 – which will house Medicaid eligibility administrative regulations; deletes incorporated material not used by the Department for Medicaid Services; and also includes language and formatting revisions to comply with KRS Chapter 13A requirements.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with an Affordable Care Act mandate which requires eligibility standards for the MAGI group and for former foster care individuals which differ from the eligibility standards for those who remain under the old/existing Medicaid eligibility rules. Deleting the incorporated material is necessary as the Department for Medicaid Services (DMS) does not use the material. Deleting the definitions is necessary as DMS is creating a definitions administrative regulation for Chapter 20. Additionally, language and formatting amendments are necessary to ensure conformity with the requirements established in KRS Chapter 13A.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with Affordable Care Act mandates.

(d) How the amendment will assist in the effective administration of the statutes: The amendment conforms to the content of the authorizing statutes by complying with Affordable Care Act mandates.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 individuals.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. The amendment imposes no action to be taken by the affected individuals.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the affected individuals.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals will be able to appeal adverse actions as prescribed in this administrative regulation.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: DMS anticipates no cost as a result of the amendment.
(b) On a continuing basis: The answer provided in paragraph (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act (Title XIX) and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding will be necessary to implement the amendment to this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used). Tiering is only applied in that a different requirements apply to the MAGI group and to the former foster care individuals as mandated by the Affordable Care Act.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 20:060
Agency Contact: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 USC 1396a(e)(14) and 42 U.S.C. 1396a(a)(10)(i)(IX).

2. State compliance standards. KRS 205.520(3) states, "to qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations - to determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations exempted from the new requirements (and to whom the old requirements continue to apply) include aged individuals [individuals over sixty-five (65) years of age or who receive Social Security Disability Insurance; individuals eligible for Medicaid as a result of being a child in foster care; individuals who are blind or disabled; individuals who are eligible for Medicaid via another program; individuals enrolled in a Medicare savings program; and medically needy individuals.

   Additionally, states are prohibited from continuing to use income disregards, asset tests, or resource tests for individuals who are eligible via the modified adjusted gross income standard.

   Federal law also prohibits the application of an income standard or resource standard, for eligibility purposes, to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment neither imposes stricter nor additional nor different responsibilities nor requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 20:060
Agency Contact: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS anticipates no revenue being generated for the first year for state or local government due to the amendments.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue being generated for subsequent years for state or local government due to the amendments.
(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year for state or local government due to the amendments.
(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years for state or local government due to the amendments.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-): .
Expenditures (+/-):

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 20:060

Summary of Material Incorporated by Reference

The material previously incorporated by reference, which is listed as follows, is being deleted from the incorporated material as the Department for Medicaid Services does not utilize the material:

1. “MA-105”, July 1992 edition; and
2. “KIM-105”, September 1992 edition.

The “MA-105”, July 1992 edition is a two (2)-page form previously used by the Department for Community Based Services in consulting with Medicaid applicants regarding application.

The “KIM-105”, September 1992 edition is a two (2)-page form previously utilized by Kentucky Automated Management and Eligibility System (KAMES) staff to notify individuals of information regarding an application for Aid to Families with Dependent Children (AFDC) benefits or Medicaid benefits.

A total of four (4) pages were previously incorporated by reference.